

No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43645**

Registration District No. **739**

Primary Registration District No. **4441**

Registrar's No. _____

1. PLACE OF DEATH
(a) County **Ray**
(b) City or town **Camden Mo.**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days **2**

3. (a) PRINT FULL NAME **Obediah Creacy**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 6 1880**
(Month) (Day) (Year)

8. AGE: Years **60** Months **8** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Wellington Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Comon Labor**

11. Industry or business _____
12. Name **Thomas Creacy**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Laura Barnes**
15. Birthplace **Wis.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Emmet Lauck**
(b) Address **Camden Mo.**

17. (a) **W/ Burial** (b) Date thereof **Oct. 18, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Wellington Mo.**

18. (a) Signature of funeral director **E. Thurman Richmond Mo.**
(b) Address _____

19. (a) **9 Jan 1941** (b) **M D Middleton**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Ray**
(c) City or town **Camden Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **16**
year **1940** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** Duration **Just**

Due to **Advanced Arterio Sclerosis**

Due to _____

Other conditions **g412**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Whit**
(Specify type of place) (e) Means of injury _____

23. Signature **EW Gaines** (M. D. or other) **M.D.**
Address **Richmond Mo** Date signed **10-17-40**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,
District File Number
14-14-1
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.